the stomach tube for rather more than a month, but by firmly plugging the external opening into the pharynx he could swallow three weeks after operation.

Cholecystitis and Infectious Angiocholitis due to Coli Bacillus—Cholecystotomy—Recovery.—LEJARS (*Gaz. Heb. de Med. et de la Chir.*, March 25, 1897) reports an interesting case of infection of the biliary passages by the coli bacillus.

He says we have to do in this case with a coli bacillus infection, without lithiasis of the gall-bladder and of the larger subhepatic ducts, and this infection has made itself manifest for two years by painful and febrile crises, which have latterly become more and more frequent. In addition the intervention took place during an acute attack, more acute and more severe than any of those previous, and had for its purpose the relief of symptoms typhoidal in nature and menacing a general septic nature.

The immediate relief produced by the cholecystotomy and drainage of the bladder was shown in the evening fall of temperature.

The case admirably demonstrated the results which such an intervention, so simple in its nature, affords. It also provided a method not only for the relief, but also for the cure of a chronic condition which had resisted all other forms of treatment.

A Case of Subphrenic Abscess followed by Empyema Successfully Treated.—MCNAUGHT (*British Medical Journal*, May 22, 1897) reports the following interesting case:

A well-nourished man, aged thirty-three years, was seized with severe epigastric pain and vomiting. His previous history showed dyspepsia, but no hæmatemesis. Morphine relieved the pain, and no further vomiting occurred.

Ten days later he had a severe, catching pain at the lower angle of the scapula. Coarse friction-sounds were audible at that point. There was a short cough, but no expectoration. Temperature 101° F., pulse 114. As there had been no exposure, the author suspected a rupture of the stomach and the formation of a subdiaphragmatic abscess. There were no signs of general peritonitis. Two days later a displacement of the lower border of the diaphragm was noted throughout its entire extent. The usual liver-dulness was replaced by tympanites, which extended from the lower costal margin as far upward as the nipple and as far back as the anterior axillary line. At the right base there was marked dulness extending from the inferior angle of the scapula, and this dulness was bounded anteriorly by a curved line running steeply down from the posterior axillary line to the costal margin. Breath-sounds were entirely absent over this area. Above the tympanitic area in front, and extending in a band two inches wide transversely along the nipple line from the sternum along the ribs to the back, there was also marked dulness. Above this the lung was resonant, and auscultation discovered moist râles. Dyspnœa was considerable, but there was very little expectoration or cough.

Forty-eight hours later the tympanitic area had increased, and splashing sounds could be heard entirely distinct from the stomach, whose tympanitic

area was also easily differentiated. A hypodermic needle drew fetid pus between the ninth and tenth ribs in the posterior axillary line, and an incision drew off a large amount of pus and gas. Serum was found in the pleura. The abscess-cavity was washed daily and drained. Pus was evacuated by aspiration after a fortnight from the pleural sac. It was, however, sweet. Resection of a rib was finally necessary, and after drainage and packing it healed.

The previous history leads the author to believe that the abscess was due to a small rupture of the stomach or duodenum, as the abscess-formation was slow. The amount of gas and the distention made the diagnosis easier.

In another case he would open the subphrenic cavity between the eighth and ninth ribs, and use siphon drainage earlier in the pleural cavity.

Chronic Prostatitis and Sexual Neurasthenia.—In discussing the relation of these diseases HOTTINGER (*Correspondenzblatt für Sch. Aertz.*, 1896, No. 6) says that many functional derangements of the genito-urinary system, which have been called purely nervous or symptoms of neurasthenia, have as their pathological and anatomical basis a chronic or other form of prostatitis, and that the so-called neurasthenia disappears as soon as this pathological condition has been cured. If these cases were only recognized early and treated properly, there would be a great diminution in the number of neurasthenic patients. A greater decrease, however, the author believes would follow the stamping out of gonorrhœa and the education of the public in the physiology of the sexual organs.

As a case in point, the author details the history of a patient who had had loss of power for four years and had detected the presence of semen in the urine for two years and a half. At the same time he had decreasing strength and loss of appetite and digestion. He had been treated for various diagnoses without avail. The microscopical examination of the urine disclosed the fact that there existed a prostatitis. The prostate was but slightly enlarged, was somewhat harder, but not especially tender; the expressed secretion showed a large number of leucocytes, some red blood-corpuscles, and spermatozoa.

Treatment *per urethram* and by drugs *per rectum* produced no results, and the patient did not begin to improve until massage of the prostate was carefully and systematically carried out. The patient improved rapidly and was cured, and was seen in perfect health two years after the time of his discharge.

Foci of Suppuration at a Distance from the Appendix in Cases of Appendicitis.—PIARD (*Arch. gén. de Méd.*, November, 1896), after considering the etiology, pathology, and symptomatology of these abscesses, considers their treatment and the indications for operation.

In considering the question of the removal of the appendix, he says that to insist upon the removal of the appendix in these cases at all hazards would be to increase markedly the gravity of the intervention. The indications are in some cases absolute, in others relative. In the presence of suppuration situated at a distance from the appendix, he says the indication for removal is only absolute in the following cases: